

Exploring the scope of practice and training of obstetricians and gynaecologists in England, Italy and Belgium

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Title: Comparing the scope of practice and training of Obstetricians and Gynaecologists in England, Italy and Belgium: a qualitative study

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Abstract

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Introduction:

Increasing numbers of doctors are moving within Europe to obtain employment [1-4] using the legislative framework set out in the EU Directive on mutual recognition of professional qualifications [5]. Yet free movement of professionals remains problematic. The directive currently stipulates the minimum hours of study required to gain a medical qualification, leaving the training content, skills required and the definition of the scope of practice to national authorities [6]. Specialty

requirements are even less well defined, only requiring that the physician has obtained speciality status in a Member State where the speciality is recognised.

This paper looks at the scope of practice of obstetrics and gynaecology (OBGYN), in England, Italy and Belgium. For our purposes, scope of practice includes patients seen, procedures performed, treatments provided, and the physician's practice environment. A physician's ability to perform competently within his or her scope of practice is understood to be determined by the physician's knowledge, skills and judgment, which are developed through appropriate training and experience. OBGYN is of particular interest due to the ethically challenging aspects of the speciality which are often culturally embedded and politicised, affecting women who move within Europe regarding their expectations of care [7]. Thus, there are both professional and patient-related imperatives to understand the commonalities and differences in OBGYN training and practice within Europe.

Some European bodies, such as the European Board and College of Obstetrics and Gynaecology (EBCOG), which has established a Standing Committee on Training Recognition) [8] and the European Union of Medical Specialists (UEMS) [9] have worked on establishing criteria for training and practice. However, these can only be advisory, given that the European legal framework for professional regulation is based on mutual recognition of national systems, rather than harmonisation. In practice, this means that the EBCOG has recognised some speciality accreditation systems in those countries that have them, such as the United Kingdom, while making available a voluntary European scheme based on a standard logbook for specialists in countries without such an accreditation system, as in Belgium and Italy.

A literature search found a few papers focusing on training in OBGYN generally [10-12], and specifically in gynaecologic oncology [13-15] and other subspecialties, [16-18] revealing marked differences in specialist training across Europe and calling for common European standards, whilst recognising the difficulty in harmonisation across Europe. A few papers also assessed the impact of the European Working Time Directive on OBGYN training in the UK [19-21], raising general concerns

about training opportunities. Whilst the lack of consistency of training and practice among European countries is recognised in these papers, there is little analysis on whether moves towards harmonisation would make any difference to clinical practice, an issue important for those implementing policies on professional mobility. This paper seeks to fill this gap by examining the commonalities and differences in training, scope of practice and experiences of obstetricians and gynaecologists in England, Belgium and Italy, while raising questions about mobility within Europe.

Methods:

Semi-structured interviews were conducted with 29 obstetricians and gynaecologists from England (9), Belgium (10) and Italy (10). Interviewees were included if they had undertaken specialty training in the respective country and were currently practising OBGYN. They were recruited through advertisements in relevant OBGYN journals and specialty organisations and personal invitations by email and phone, using purposive and snowball sampling techniques. Trainees (2) and those on specialist registers (27) were included, working in both public and private sectors, from across the three countries. Interviews were conducted in the native language, following a common topic guide that covered themes relating to scope of practice. These include training; work experience (covering procedures performed, treatments available and practice environment); emerging changes to practice, persisting challenges.

Interviews were conducted either in person, via telephone or Skype. All participants were presented with an information sheet, and consent obtained for the interviews to be audio-recorded. All interview materials were stored securely to assure confidentiality.

[Table 1]

Interviews were transcribed in their respective countries, then coded and analysed using a common coding frame that had been developed both deductively and inductively. Care was taken to ensure that common terminology drawn from collectively understood concepts were applied throughout

the analysis to ensure consistency and accuracy. In the deductive stage, the data were mapped according to the three main themes of the topic guide. The inductive stage selected themes based on their frequency in the interview data and their ability to identify similarities and differences between countries, within which subthemes emerged. In this paper, we focus on themes specific to OBGYN rather than to medical practice in general.

Data were initially analysed within each country and then the completed coding frames, written summaries and key quotes (translated into English) were cross-analysed among the researchers to identify emerging themes and comparisons.

Results

The training experience

Training pathways

To set the practice of OBGYNs in different countries in context, it is important to understand their training and career paths. Figure 1 was compiled from interview data, and cross-checked with desk research.

[Figure 1]

Whilst interviewees reported variability among individual medical schools within countries, the early years of undergraduate training were dominated by theory, with patient contact commencing from the third year, although in some this was earlier. All finished with a Bachelor's degree in Medicine and Surgery or equivalent, as set out in the European Union's Bologna process [22].

Speciality training

All three countries have defined postgraduate OBGYN training programmes, on completion of which they are able to practise as an OBGYN specialist/consultant. Applications to enter the programmes are made through the respective university or other training authority. In each case, admission is

based on either written or oral exams and formative interviews, which participants from all countries described as competitive. In all countries established specialists noted that training programmes are now much more rigorous and structured than systems that had existed when they undertook their training.

[Table 2]

[Evidence presented in Table 3]

In all countries, training takes place in wards, outpatient clinics and operating theatres, with trainees expected to achieve competency in certain procedures and skills, taking on more responsibility with each year of training. However participants in all countries voiced frustration about limited opportunities to practice certain procedures, often competing with more senior trainees. This has been exacerbated by the limitation of training hours to 48 hours per week imposed by the European Working Time Directive (EWTD), resulting in concerns amongst trainees about the acquisition of skills and competencies, as well as staffing challenges. Others commented that the EWTD has led to more fragmented training, developing a “handover mentality”, and that training “impeded individuality” among trainees, resulting in reduced job satisfaction amongst current trainees. Senior consultants in Belgium and the UK were especially vocal on this issue, contrasting the current situation with the longer hours that they worked when training themselves.

Subspecialty training

The EBCOG lists a number of subspecialties within the speciality of Obstetrics and Gynaecology: Perinatal Medicine, Gynaecological Oncology, Reproductive Endocrinology and Uro-gynaecology [8]. However, within countries, terminology and boundaries differ. Table 4 lists those identified by interviewees in each country.

[Table 4]

Only in England do the recognised subspecialties match those listed by the EBCOG, although two English consultants noted how maternal medicine is increasingly being seen as a separate subspecialty. Belgium and Italy recognise Obstetrics and Gynaecology as subspecialties in themselves, along with Fertility and Perinatology respectively.

Whilst all OBGYN trainees can remain generalists, England and Belgium have optional subspecialty training programmes incorporated into the final years of specialty training, as shown in Figure 1. In Belgium, participants described seeking subspecialisation training abroad due to the absence of formal subspecialty training programmes in country. Italy has no formal subspecialty training, but a few interviewees reported that formal subspecialisation is only achieved through academic research.

The experience at work

[Evidence presented in Table 5]

The clinical organisation of OBGYN services also varies among countries. Without formal subspecialty training, Italian OBGYN consultants remain generalists covering all subspecialties - “*we deal with everything*” (IT06) – only referring complex cancer or emergency cases to specialist centres. OBGYN practice is most specialised in the Belgian and English public sectors; departments are often divided between obstetrics and gynaecology, with some gynaecologists rarely being involved in obstetric care and vice versa. In England, consultants also tend to focus their expertise, but they often remain engaged in a broad range of OBGYN issues through teaching and on-call responsibilities.

Gynaecologists in Belgium and England, in principle, work in secondary and tertiary facilities. In Italy they also work in primary care settings. In Belgium however there is no GP gatekeeper system, giving patients direct access to secondary and tertiary care facilities. Specialists usually have a private ambulatory practice alongside their hospital activities.

Tension between public and private practices

Unlike in the primarily public health systems in England and Italy, the Belgian interviewees presented a tension between public and private practices and the monetisation of OBGYN care. All Belgian hospitals are non-profit making, but self-employed doctors can charge supplemental fees for treatment in private rooms. There were concerns about the profit-driven approach of OBGYNs who operate both in publicly funded hospitals and run their own private (ambulatory) practice – as many do, siphoning off wealthier patients for private care. However, it was reported that Belgian women prefer private care for childbirth as they pay more to be treated by their chosen specialist. It was also noted that public services treat more patients from lower socio-economic groups, often with more complex (e.g. administrative and language) problems.

Multidisciplinarity of the work

Recognising the increase in subspecialisation, interviewees from all countries commented on the multidisciplinarity of their work, describing working alongside other different specialists. Much of this has come about from the increase in older patients with comorbidities, working particularly closely with oncologists for cancers and endocrinologists for diabetes. However, in Belgium, a few participants suggested that this new development of multidisciplinarity is not accepted by the older generation of doctors.

Changes and challenges for the future

Changes in practice

In all countries there were concerns about the rise in caesarean sections, almost doubling in some places. Some interviewees attributed this to patient demand, work-planning by doctors to avoid out-of-hours work, but also a rise in defensive medicine in response to growing malpractice litigation. Whilst many Italian interviewees attributed the rise in caesarean sections mostly to defensive medicine, in England concerns focused more on women who refused caesarean sections when the OBGYN felt it was indicated clinically.

All countries recognised the important role that technology has played in advancing the scope of OBGYN, giving the example that “*the baby really became a patient with the progress of ultrasounds*” (BE06), which in turn will be requiring reassessment of the legal situation. Interviewees in all countries also discussed how laparoscopy had made less invasive procedures possible, with correspondingly shorter hospital stays.

Ethical issues arising from technological advances

Advances in technology have made the once impossible possible, raising many new contentious issues for OBGYNs that need to be addressed. Advances in imaging technologies have increased demand for abortions, whilst developments in in-vitro fertilisation have made assisted reproduction possible for many more couples. However these issues are understood differently in each country, reflecting legislative and cultural differences.

In Italy there is a strong anti-abortion movement, with few abortion clinics or doctors willing to work in them. Seven of the ten Italian OBGYNs interviewed were anti-abortionists, meaning that they could not be involved in abortions or they would lose their anti-abortionist status, an important matter for those associated with Catholic health institutions. Italian OBGYNs also reported individually taking a moral stance against abortion. The UK mainland (excluding Northern Ireland) and Belgium have more liberal laws, viewing it in both a medical and moral context, although doctors can refuse to perform these procedures.

In England, interviewees were more concerned about technologies related to fertility and assisted reproduction, particularly where the woman has co-morbidities such as cancer or heart disease or older women past the natural age of reproduction. A Belgian interviewee also raised concern over artificial insemination for homosexual couples, which is legal in England but not in Italy, reflecting the diversity of legislation on procreation issues within Europe.

Gender shift in the profession

In England, interviewees commented spontaneously on the gender shift and increase in female OBGYN practitioners, something not discussed in Belgium or Italy although subsequently we learned that there are also similar discussions ongoing regarding the gender balance in the specialty in these countries. There was also a sense of “*feminising the profession*” which, when combined with greater patient empowerment and responsiveness to patient needs, were seen as contributing to better quality of care. A steady rise in the number of female gynaecologists has also been seen in Belgium, although in Italy, informants reported that the OBGYN speciality remains male-dominated, with fewer initiatives to empower female patients.

Comments

Although European legislation assumes that training, knowledge and skills in each medical speciality are comparable across Europe, this has rarely been assessed and what studies do exist show that it is rarely the case [11-18]. This study adds to a growing literature that is beginning to inform the development of European standards [13, 23-25]. It shows that, whilst sharing basic elements of practice, there is great variety in the training and practice of OBGYN across these three countries and the structures within which they practice despite being qualified to practice in all Member States. Training structures reflect the working environment, with implications for how OBGYN and its subspecialties are taught and practiced among different countries.

The greatest differences reported in this study relate to ethically contentious issues linked to technological advances in medical practice. Study participants described ethical concerns around abortion and fertility issues, indicating distinct variations in how these issues define certain aspects of the structure of OBGYN practice in the respective countries. This, in turn, has implications for the training and experience of their practitioners, posing challenges for doctors who practice in a country with different legislation from their home nation; for example an antiabortionist may feel conflicted to operate in a liberal pro-choice healthcare system. Abortion and fertility are both

important elements of cross-border care provision for those unable to access such services in their home country.

Interviewees also recognised social, political and economic changes in the OBGYN speciality in recent years, such as the increasing age of mothers, the impact of the EWTd and reductions in funding. Technology has been a major driver, creating many new possibilities in OBGYN care, including the care of those with co-morbidities, as well as ethical concerns. However current austerity measures may mean that not all countries are investing in these technological advances. Equally it can be seen that some countries are adopting more feminised and liberal approaches to OBGYN services, meaning that some countries may adopt new practices, whilst others lag behind.

Recognising the variations in such an emotive and ethically contentious specialty such as OBGYN, harmonisation of these disparate and culturally-embedded healthcare systems still seems a distant goal. This paper captures some of the differences in training and practice between three European countries, adding a qualitative dimension to what is already known, thereby contributing to the sparse literature on this topic.

Strengths and Limitations:

Following qualitative methodological practices, all interviews were conducted and analysed following a common topic guide and coding frame. Conducting interviews in different languages which were then translated risks missing details and context, although queries were clarified together between the researchers. This study also only focuses on three countries in Europe and therefore cannot necessarily be generalised to reflect the situation in Europe. Nor does it cover all aspects of medical training. However we believe that it does fairly reflect the issues in these three countries.

Conclusion:

This study has shown that the practice of OBGYN varies considerably in three European countries, highlighting the need for further research to characterise the scope of practice and training in a larger number of countries that can inform future policies on professional mobility. However, even though these findings cannot be generalised beyond the countries concerned, they reveal sufficient diversity to challenge the assumption within European legislation that existing specialty training schemes are sufficiently consistent to justify mutual recognition. Instead, there is a need for an open debate on the differences that exist.

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Table 1 Characteristics of interviewees

Country	England	Belgium	Italy
Gender	9F, 0M	3F, 7M	4F, 6M
Practice setting	9 public, 1 of whom also practiced private	7 from University hospitals (1 who also had a private ambulatory practice); 2 private ambulatory practices	8 from university hospitals, 1 in a small public hospital, 1 in primary care
Level	2 trainees, 7 specialist consultants	10 consultants	10 consultants

Table 2 Comparative components of OBGYN speciality training across the UK, Belgium and Italy

	UK	Belgium	Italy
Management of specialty training	Regional local education authorities connected to networks of training hospitals	Post-graduate university linked to teaching hospital	Post-graduate specialty programme linked to teaching hospital
Location of specialty	Annual (or more	Different hospitals	Commonly at same

training	frequent) rotation across hospitals in deanery network	across university hospital network	hospital throughout training, although opportunity to train at different hospitals
Structure of speciality training	OBGYN rotations covered throughout 7 years, often with subspecialty focus depending individual career path	2 years of Obstetrics, two years of Gynaecology, one year of Fertility or other specialty; surgery only in final year	2 years of Obstetrics, two years of Gynaecology, one year of subspecialty

Table 3 Evidence on challenges in OBGYN specialty training

Issue	Evidence
Shift from informal networks for specialty training	<i>"[In the past] you just went to the Chief of Development of the university, you ask him 'I want to become a specialist' and he said yes or no" (BE1).</i>
Concerns over the impact of the European Working Time Directive on specialty training	<p><i>"Now you have to push so hard to get your surgical skills up to scratch because with the 48-hour week, European Working Time Directive" (EN2)</i></p> <p><i>"(in my time) when we were on call, we worked also the next day. Now, the young specialist candidates take off the next day, so they have one day less for their training, per week. During 5 years, it means almost one year less! It causes problems" (BE8)</i></p> <p><i>"I do surgical procedures that last 6 hours and if you have trainees who are told they have to rest every 4 hours then how are they going to build their stamina?" (EN4)</i></p>
Recognising distinct subspecialties	<i>"Uro-gynaecology is absolutely unrecognized in Belgium, while in Holland and France it is" (BE10)</i>

Table 4 Range of subspecialties in England, Belgium and Italy

England	Belgium	Italy
Reproductive health	Reproductive medicine/Fertility	Perinatology
Foetal medicine (<i>incl maternal medicine</i>)	Obstetrics, <i>including foetal and maternal medicine</i>	Obstetrics
Uro-gynaecology	Gynaecology, <i>including uro-gynaecology and oncology</i>	Gynaecology
Gynae-oncology		

Table 5 Evidence on challenges in OBGYN practice

Issue	Evidence
Division between Obstetrics and Gynaecology	<p><i>"In private, they do everything...But here (in the hospital) everything is separated. I do not do deliveries anymore because I am only doing uro-gynaecology." (BE09)</i></p> <p><i>"I'm not allowed any more to do things that I'm not accredited to, given the subspecialty" (BE10)</i></p>
Tensions between public and private sector	<i>"A specialist will make differences between patients; not according to their pathologies but based on their wallet" (BE09)</i>
The need for a multidisciplinary approach	<p><i>"The patient population is getting older... fatter and more medically complicated people are now pregnant" (EN05)</i></p> <p><i>"A multidisciplinary approach [is taken] at an everyday level" (EN05)</i></p>
Resistance to multidisciplinary approaches	<i>"Those who are more than 55 years, they do not refer, because... for them it is a failure to refer the patient. For the new generation... we like to refer as much as possible. We are not ashamed to say that our competencies are limited." (BE05)</i>
Rise in caesarean section due to defensive medicine practice	<i>"Before the caesareans were about 10-12 % and now it represents 25% because doctors are afraid. If there is the any risk, they do not take it and make a caesarean." (BE05)</i>

practice

Ethical challenges in OBGYN generally *"In ethics, we have the abortions; then in fertility, we have the problem of who we should make pregnant" (BE09)*

Ethical challenges over abortion in Italy *"Every physician can decide whether to do the abortion or not. Private structures decide for themselves, but the public structure should have always a physician able to make an abortion. In religious structures it is forbidden to perform abortion" (IT02)*

"I cannot handle people wishing to abort children who are human beings" (IT01)

Ethical challenges in fertility *"Women desperately trying to get pregnant and you know that they're not really going to get pregnant because they are 44 and overweight and you can't quite get yourself to say that." (EN02)*

Feminisation of OBGYN *"Women as patients were more able to liaise with their carers, more able to speak out about what they wanted and actually their carers understand intuitively what they want" (EN03)*

The role of OBGYN *"The gynaecologist is the GP of the woman... there are too many gynaecologists, and (women) go to the gynaecologist for primary interventions such as pap smears." (BE09)*

Figure 1 Current training pathways for OBGYN Specialists in the UK, Belgium and Italy

United Kingdom	5 -6 yrs Dependent on school	1	2	1	2	3	4	5	6	7	Completion
	Medical School	Foundation training		Specialty Training							Certificate of Competition of Training
		Specialty rotations		MRCOG exams from Y2 and Y5, plus E-portfolio					Advanced Training Modules or sub-specialisation training		

Belgium	6 yrs formally 7 yrs	6 mths	1	2	3	4	5	Completion
	Medical School	Test training for speciality	Specialty Candidate Training including Subspecialty training					Medical Doctor Specialist in OBGYN
		Specialty entrance exam	Annual exams plus portfolio throughout training					2-4 year subspecialty fellowship

Italy	6 yrs	1	2	3	4	5	Completion
	Medical School	Specialty Training					Postgraduate Diploma in OBGYN
	Specialty entrance exam	Annual exams, plus thesis in final year					No formal training subspecialty

Notes: MRCOG – Membership of the Royal College of Obstetrics and Gynaecology – the professional body that supervises training and conducts exams in the UK.